

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

937

00485

CERTIFICATE OF DEATH

Reg. Diat. No. 131

1. PLACE OF DEATH:

County... Frederick
 City or town... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 1 month 16 days
 Hospital, institution, or street address where death occurred:
Frederick City Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Carroll
 City or town... Harrisville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. Mt. Airy, Md
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Mary Adams

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Eugene A. Adams

7. Birth date of deceased (mo., day, yr.) April 15, 1884 6. (c) If alive, give age 69 years

8. AGE: Years 60 Months 8 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll Co. Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name FRANK HOOPER

13. Birthplace MARYLAND

14. Maiden name Katherine Kronin

15. Birthplace MARYLAND

16. Informant Mr. E. A. Adams

Address Mt. Airy, Md

17. BURIAL Date thereof 1-10-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Taylorville

Location Taylorville, Carroll Co. Md

18. Funeral director G. M. Walters

Address Weyfield Md

19. 8 Jan 1945 Elizabeth Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6, 1945 at 10:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 18, 1944 to Jan 19, 45

and that I last saw him alive on Jan 19, 45

Immediate cause of death Heart Coronary Thrombosis DURATION 1 day

Due to Arteriosclerosis

Other conditions Hypertension 2 hrs

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. Gustav Pease M.D. M. D. or other

Address Frederick, Md Date signed _____

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX OF MOTHER

12. DATE OF MARRIAGE

13. PLACE OF MARRIAGE

14. DATE OF DEATH

15. TIME OF DEATH

16. CAUSE OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX OF MOTHER

20. DATE OF MARRIAGE

21. PLACE OF MARRIAGE

22. DATE OF DEATH

23. TIME OF DEATH

24. CAUSE OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX OF MOTHER

28. DATE OF MARRIAGE

29. PLACE OF MARRIAGE

30. DATE OF DEATH

31. TIME OF DEATH

32. CAUSE OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX OF MOTHER

36. DATE OF MARRIAGE

37. PLACE OF MARRIAGE

38. DATE OF DEATH

39. TIME OF DEATH

40. CAUSE OF DEATH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX OF MOTHER

44. DATE OF MARRIAGE

45. PLACE OF MARRIAGE

46. DATE OF DEATH

47. TIME OF DEATH

48. CAUSE OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX OF MOTHER

52. DATE OF MARRIAGE

53. PLACE OF MARRIAGE

54. DATE OF DEATH

55. TIME OF DEATH

56. CAUSE OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX OF MOTHER

60. DATE OF MARRIAGE

61. PLACE OF MARRIAGE

62. DATE OF DEATH

63. TIME OF DEATH

64. CAUSE OF DEATH

65. PLACE OF BIRTH

66. DATE OF BIRTH

67. SEX OF MOTHER

68. DATE OF MARRIAGE

69. PLACE OF MARRIAGE

70. DATE OF DEATH

71. TIME OF DEATH

72. CAUSE OF DEATH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. SEX OF MOTHER

76. DATE OF MARRIAGE

77. PLACE OF MARRIAGE

78. DATE OF DEATH

79. TIME OF DEATH

80. CAUSE OF DEATH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX OF MOTHER

84. DATE OF MARRIAGE

85. PLACE OF MARRIAGE

86. DATE OF DEATH

87. TIME OF DEATH

88. CAUSE OF DEATH

89. PLACE OF BIRTH

90. DATE OF BIRTH

91. SEX OF MOTHER

92. DATE OF MARRIAGE

93. PLACE OF MARRIAGE

94. DATE OF DEATH

95. TIME OF DEATH

96. CAUSE OF DEATH

97. PLACE OF BIRTH

98. DATE OF BIRTH

99. SEX OF MOTHER

100. DATE OF MARRIAGE

101. PLACE OF MARRIAGE

102. DATE OF DEATH

103. TIME OF DEATH

104. CAUSE OF DEATH

105. PLACE OF BIRTH

106. DATE OF BIRTH

107. SEX OF MOTHER

108. DATE OF MARRIAGE

109. PLACE OF MARRIAGE

110. DATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

00486

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Point of Rocks
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

BABY BOY ADCOCK

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Point of Rocks
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war NONE

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) January 21, 1945

6. (c) If alive, give age _____ years

8. AGE: Years Months Days It less than one day
0 0 0 5 hrs. 5 min.9. Birthplace Point of Rocks, Maryland
(Town, county, and state)10. Usual occupation At Home11. Industry or business At Home12. Name Marvin Adcock13. Birthplace Frederick Co., Maryland14. Maiden name Lorraine Scheetz15. Birthplace Frederick Co., Maryland16. Informant Mrs. Marvin AdcockAddress Point of Rocks, Maryland17. Burial Date thereof Jan. 22, 1945
(Burial, cremation, or removal: Which) (month) (day) (year)Cemetery or crematory St. Paul's CemeteryLocation Point of Rocks, Maryland18. Funeral director M. R. Etchison & SonAddress Frederick, Maryland19. 22 Jan 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1945, at 8: P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 21, 1945 to Jan. 21, 1945
and that I last saw him alive on Jan. 21, 1945Immediate cause of death Pre-natal, exhaustion
DURATION 5 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Elizabeth G. Heck M. D. or other _____Address Southville, Va Date signed 1/22/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

00487

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since March 30, 1944
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since March 30, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route #1
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Margaret L. Adkins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband Mr. Roy T. Adkins

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 17, 1920

8. AGE:

Years

Months

Days

If less than one day

24718

hrs.

min.

9. Birthplace

Princess Anne, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

David Dryden

13. Birthplace

Pocomoke, Maryland

MOTHER

14. Maiden name

Mattie Powell

15. Birthplace

Pocomoke, Maryland

16. Informant

Deceased

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

16. Funeral director

Address

19. (Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 19 45 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 30 19 44 to Jan. 4 19 45
 and that I last saw her alive on January 4 19 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

3 Yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. XXXXXAddress State Sanatorium, Md. Date signed 1/5/45

CERTIFICATE OF DEATH

State of Maryland

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

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FEB 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

00488

139

Reg. Dist. No.

1. PLACE OF DEATH: Frederick
 County.....
 City or town..... State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Nov. 22, 1944
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since Nov. 22, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... St. Mary's
 City or town..... Patuxent River
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... N.A.S., V.R.-9
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Naomi C. Arthur

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband Samuel E. Arthur
 7. Birth date of deceased (mo., day, yr.) August 20, 1912 6. (c) If alive, give age 39 years

8. AGE: Years 32 Months 5 Days 0 It less than one day
hrs.min.

9. Birthplace..... Baltimore, Md.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

FATHER 12. Name..... George Mills
 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name..... Catherine ?
 15. Birthplace Baltimore, Md.

16. Informant..... Samuel E. Arthur (Husband)
 Address.....

17. Burial Date thereof 1/24/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery Gravestone Fountain Green
 Location..... Darlington, Maryland

19. Funeral director..... M.L. Creager & Son
 Address..... Thurmont, Maryland

19. (Date rec'd by registrar) 1/20/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 19 45 at 8:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 22 19 44 to Jan. 20 19 45
 and that I last saw her alive on January 20 19 45

Immediate cause of death.....
Pulmonary Tuberculosis

DURATION
3 Yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... M. D. XXX

Address..... State Sanatorium, Md. Date signed 1/22/45

CERTIFICATE OF DEATH

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FEB 6 1945

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13107

CERTIFICATE OF DEATH

00489

Reg. Dist. No. 744 140

1. PLACE OF DEATH:

County... Frederick
City or town... Rural Hieton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... FrederickCity or town... Rural Hieton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war... no

3. (a) FULL NAME

Alice Margaret Biddinger

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Chas Biddinger6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) Dec 25 - 1870

8. AGE:

Years 24 Months 0 Days 18 hrs. min.

9. Birthplace

Ladiesburg Fred Co. Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Elias Fagle

12. Name

Ladiesburg Md

13. Birthplace

Ladiesburg Md

14. Maiden name

Clayanna Cyler

15. Birthplace

Ladiesburg Md

16. Informant

Keymar Md

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof Jan 16 - 1945
(month) (day) (year)

Cemetery or crematory

Laughs Cem

Location

Ladiesburg Md

18. Funeral director

M. S. Creger Roy

Address

Thurmont Md19. Jan. 16, 1945

(Date rec'd by registrar)

Anna M. JonesRev Blanche S. Cyler

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 19 45 at 4:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 19 41 to Jan. 13 19 45and that I last saw her alive on Jan. 11 19 45

Immediate cause of death

Septicemia probably
due to StaphylococcusDue to Infection through
trophic ulcer in left leg

Due to

Other conditions Chronic Tuberculosis
Aspirin, Scurvy, Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.Address Terrington, Md. Date signed 1/15/45

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY

RECEIVED
FEB 2 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

Reg. Dist. No. 135

1. PLACE OF DEATH:

County.....*Frederick*
 City or town.....*Rural - Myersville*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*Thirty years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....*Maryland* County.....*Frederick*
 City or town.....*Rural - Myersville*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*Middle Point*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Wade Blickenstaff

3. (b) Social Security Number

4. Sex.....*Male* 5. Color or race.....*White* 6.(a) Single, married, widowed, or divorced.....*Married*

6.(b) Name of husband or wife.....*Olie Wolfe*
Blickenstaff 6.(c) If alive, give age.....*42* years
 7. Birth date of deceased (mo., day, yr.).....*January 19, 1887*

8. AGE: Years.....*57* Months.....*11* Days.....*24* hrs..... min.

9. Birthplace.....*W. Wolfsville - Frederick, Md.*
 (Town, county, and state)

10. Usual occupation.....*Farmer*

11. Industry or business.....*Own*

12. Name.....*George W. Blickenstaff*

13. Birthplace.....*Maryland*

14. Maiden name.....*Mary B. Shawe*

15. Birthplace.....*Maryland*

16. Informant.....*Mrs. Gene Blickenstaff*

Address.....*Myersville, Md.*

17. Burial, cremation, or removal.....*Christ* Date thereof.....*Jan 6, 1945*
 (month) (day) (year)

Cemetery or crematory.....*Grossnickles*

Location.....*Rt. Myersville, Md.*

18. Funeral director.....*Thomas B. Birtch*

Address.....*Myersville, Md.*

19. Jan 6 1945 Charles L. Leatherman
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Jan 3* 19*45* at *10:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 4 19*44* to *Jan 3* 19*45*
 and that I last saw him alive on *Jan 2* 19*45*

Immediate cause of death.....*Myotrophic Lateral Sclerosis* DURATION.....*2 yrs*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....*None*
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....*J. E. Harp M.D.* M. D. or other.....*1-4-45*

Address.....*Middle Point* Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

00490

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MAR 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

00491 131
Reg. Dist. No.

1. PLACE OF DEATH:

County Fredrick
 City or town Fredrick - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 wks
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Fredrick
 City or town Middletown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Charles V Bowlus

3. (b) Social Security Number

no

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sallie S. Bowlus
 6. (c) If alive, give age 82 years
 7. Birth date of deceased (mo., day, yr.) July 24, 1867
 8. AGE: Years 77 Months 6 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Middletown Fred. Co. Md.
 (Town, county, and state)

10. Usual occupation Day laborer

11. Industry or business _____

12. Name Edward S. Bowlus

13. Birthplace Middletown, Md.

14. Maiden name Lucretia C. House

15. Birthplace Middletown - Maryland.

16. Informant Lucretia Bowlus

Address Middletown, Md.

17. Burial Date thereof 1-30-45
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or Reform Cemetery

Location Middletown, Md.

18. Funeral director Bladhill Co.

Address Middletown, Md.

19. 30-Jan 19 45 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 19 45 at 6:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from dead 19 19
 and that I last saw h. 117 alive on 19

Immediate cause of death unknown

Due to Death may have been connected with

Due to auto accident occurring on Oct 20 '44.

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results Cause of death unknown

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 10/20/44

Where did injury occur? Middletown Fred. Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Pedestrian - traffic accident Injured at work? no

23. SIGNATURE R. W. Bow M. D. or other _____

Address Fredrick, Md Date signed 2-6-45

Ad. inf. re cause of death: from report from Com. of Motor Vehicles - 4/4/45. a.s.

STATE OF MONTANA DEPARTMENT OF HEALTH

1945

CERTIFICATE OF DEATH

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FEB 13 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157-D

CERTIFICATE OF DEATH

00492

Reg. Dist. No. 141

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29.5m / day

Hospital, institution, or street address where death occurred:

Schnauffer HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 723 East Holmes St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Edward Brauner Jr

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

July 27-1938

8. AGE:

Years

Months

Days

If less than one day

651

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

45

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan 2819. 45 at 3:30 M

2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 24 19. 45 to Jan 28 19. 45

and that I last saw him alive on

Immediate cause of death

decompensated heart

Due to

congested heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed Jan 28-45

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00493

Reg. Dist. No. 131

1. PLACE OF DEATH;
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
332 East Patrick Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 332 East Patrick Street
(If rural, give LOCATION)
None
2. (a) If veteran, name war

3. (a) FULL NAME

MARY BECK BRENGLE

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W
6. (b) Name of husband or John M. Brengle
7. Birth date of deceased (mo., day, yr.) June 1, 1869 8. (c) If alive, give age _____ years
8. AGE: Years 75 Months 7 Days 17 It less than one day _____ hrs. _____ min.

8. Birthplace Frederick-Frederick-Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name John R. Baer

13. Birthplace Frederick County Maryland

14. Maiden name Margaret Schwearing

15. Birthplace Frederick County Maryland

16. Informant Richard P. Baer

Address 332 E. Patrick St., Frederick, Md.

17. Burial Date thereof 1/20/45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or St. Johns Cemetery

Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 19 Jan 19 45 Elizabeth B. Heck
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 19 45, at 5:22 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Jan 18 1945

and that I last saw her alive on Jan 18 19 45

Immediate cause of death Cardiac DURATION 8

Due to Ischemic

Due to Ischemic

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Dates of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. A. Hedger M. D.

Address Frederick, Maryland Date signed 1-19-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

SEX

PLACE OF BIRTH

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00494

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 14, 1869

8. AGE: Years 75 Months 11 Days 14 If less than one day
 hrs. min.

9. Birthplace Frederick County, Maryland10. Usual occupation laborer

11. Industry or business

12. Name Samuel Carter13. Birthplace Howard County, Maryland14. Maiden name Julia Smith15. Birthplace Howard County, Maryland16. Informant Elizabeth H. HeschAddress Frederick, Md.17. Buried Date thereof 1/30/45

(Burial, cremation, or other. Which?) (month) (day) (year)

Cemetery or crematory Fairview CemeteryLocation Frederick, Md.18. Funeral director W. R. Edmonson + SonAddress Frederick, Md.19. 29 Jan 19 45 Elizabeth H. Hesch

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 S Court

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 19 45, at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 1 19 45 to Jan 28 19 45and that I last saw him alive on Jan 27 19 45.Immediate cause of death Coronary - Vascular - DiseaseDisease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Howard W. Ah M. D.

M. D. or other

Address Frederick, Maryland Date signed 1-29-45

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FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00495
144

1. PLACE OF DEATH:

County FrederickCity or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County FrederickCity or town Middletown P.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war none

3.(a) FULL NAME

Charles Thomas Castle

3.(b) Social Security Number

none

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

✓6.(b) Name of husband or wife unknown

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 18598. AGE: Years 85 Months 1 Days 26 If less than one day _____ hrs. _____ min.9. Birthplace Middletown, Fredk. Co., Md.
(Town, county, and state)10. Usual occupation day laborer

11. Industry or business

12. Name Rezin Castle13. Birthplace Middletown14. Maternal name Ann Rebecca Mercer15. Birthplace Frederick16. Informant William ShefferAddress Middletown17. Burial Date thereof 1 16 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LutheranLocation Middletown Md.18. Funeral director Gladhill Co.Address Middletown, Md.19. Jan 16 1945 Anna M. Jones
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945 at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7 1945 to Jan. 14 1945and that I last saw him alive on Jan. 7-1945Immediate cause of death Compensating apthStomach

DURATION

3 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James T. Gray M.D.Address Thurmont Md M. D. or other _____Date signed 1/15/45

RECEIVED
FEB 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

00496

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County... Frederick
 City or town... Buckeystown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick
 City or town... Buckeystown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... None

3. (a) FULL NAME

CLARA BELLE CROMWELL

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married? widowed, or divorced Widowed
 B. (b) Name of husband or wife Carlton Cromwell
 7. Birth date of deceased (mo., day, yr.) Jan. 4, 1872
 8. AGE: Years 72 Months 11 Days 27 If less than one day hrs. min.

9. Birthplace... Virginia
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... Home

12. Name... Joseph Tavenner

13. Birthplace... Loudon County, Virginia

14. Maiden name... Anna Jones

15. Birthplace... Loudon County, Virginia

18. Informant... C. Merhl Cromwell

Address... Buckeystown, Md.

17. Burial Date thereof... Jan. 4 1945

(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory... Mount Olivet Cemetery

Location... Frederick, Maryland

18. Funeral director... C.E. Cline and Son

Address... Frederick, Maryland

19. 3 Jan 1945 Elizabeth G. Heck Registrar

(Date rec'd by registrar) 19 45

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 1st. 1945 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Jan 1 1945

and that I last saw him alive on Dec 31 1944

Immediate cause of death Acute myocarditis DURATION 2 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Elizabeth G. Heck M. D. or other

Address... Frederick, Md. Date signed... Jan 2 1945

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

Ms. 7. C. Rauten

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County FREDERICKVillage or City URBANALength of residence in city or town where death occurred 4 yrs.No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME ATTIE LEE GRIMES DAVIS(a) Residence: No. URBANA MD.
(Usual place of abode)

St. _____ Ward _____

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEM.</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>WIDOWED</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>THOMAS R. DAVIS</u>		
6. DATE OF BIRTH (month, day, and year) <u>6-10-1871</u>		
7. AGE Years <u>73</u>	Months <u>7</u>	Days <u>17</u>
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>HOUSE WIFE</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>OWN HOME</u>	
	10. Date deceased last worked at this occupation (month and year) <u>11-7-1944</u>	
		11. Total time (years) spent in this occupation <u>LIFE</u>

12. BIRTHPLACE (city or town) HYATTSTOWN
(State or country) MONTGOMERY MD.13. NAME WILLIAM A. GRIMES14. BIRTHPLACE (city or town) _____
(State or country) MARYLAND15. MAIDEN NAME MARY E. McELFRESH16. BIRTHPLACE (city or town) _____
(State or country) MARYLAND17. INFORMANT MARY Z. YOUNG
(Address) FREDERICK MD18. BURIAL, CREMATION, OR REMOVAL
Place JAMESVILLE MD. Date 1-30, 194519. UNDERTAKER W. L. BURDETTE
(Address) HYATTSTOWN MD.20. FILED Jan 29, 1945 W. L. Burdette
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 27, 1945
(Month) (Day) (Year)22. I HEREBY CERTIFY That I attended deceased from
March 1, 1944, to Jan 27, 1945I last saw him alive on Jan 28, 1943; death is said

to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Cerebral Hemorrhage Date of onset May 1944
Acute bronchitis Jan 10/45
Broncho-pneumonia Jan 19/45

Other Contributory Causes of importance:

Arterio-sclerosis 1935

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or Injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Emmet P. Roop(Address) New Market, Md.

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel, etc.* For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as *spinner, weaver, etc.*

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill, etc.*

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer, etc.* Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as *carpenter, painter, machinist, etc.* Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., *heart failure, asphyxia, asthenia, etc.* As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

00498

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
City or town Frederick - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?
1/2 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Smithsburg Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. Wolfersville -
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Infant Delanter

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced Twin - # 2
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Jan 30 1945 6.(c) If alive, give age years
8. AGE: Years 0 Months 0 Days 0 If less than one day 2 hrs. 0 min.
9. Birthplace Smithsburg Md. R#1
(Town, county, and state)
10. Usual occupation

11. Industry or business

12. Name Glenn J Delanter
13. Birthplace Frederick Co Md -
Mary Abcenda Klein -
14. Maiden name Frederick Co Md -
15. Birthplace Morgans Ledge
16. Informant Emergency Hospital -
Address Smithsburg Md. R. 2 D E.
17. Burial (Burial, cremation, or removal, which?) Date thereof Feb 1 1945
(month) (day) (year)
Cemetery or crematorium Wolfersville Cem
Location Wolfersville Md.
18. Funeral director Emory Frye
Address Smithsburg Md. R. 2 D E.
19. 2 Feb (Date rec'd by registrar) 19. 45 Elizabeth G. Heck (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945 at 9:10 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1945 to Jan 30 1945 and that I last saw her alive on Jan 30 1945
Immediate cause of death Pneumonia
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

2 hrs

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Harp Md M. D. or other
Address Smithsburg Md Date signed 2-1-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

CERTIFICATE OF HEALTH

STATE OF NEW YORK

FILE NO. 100-100000

RECEIVED

FEB 12 1945

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1672

00499

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
74 Lincoln Apartments
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 74 Lincoln Apartments
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war

3. (a) FULL NAME
WILLIAM ARNOLD DELAUTER

3. (b) Social Security Number
None

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 18, 1944 8. (c) If alive, give age

8. AGE: Years Months Days If less than one day
1 13

9. Birthplace Frederick-Frederick-Maryland
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name Charles L. Delauter, Sr.

13. Birthplace Frederick County Maryland

14. Maiden name Mabel B. Roberts

15. Birthplace Frederick County Maryland

16. Informant Mrs. Charles L. Delauter, Sr.

Address 74 Lincoln Apts., Frederick, Md.

17. Burial Date thereof 2/2/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Colored Cemetery

Location Point of Rocks, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 1-Feb-45 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1945, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30, 1945 to Jan 31, 1945 and that I last saw him alive on Jan 30, 1945

Immediate cause of death anemia and
hypertension
 Due to impure feeding
and care

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Hedgn M. D.

Address Frederick, Maryland Date signed 2-1-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00500

Reg. Dist. No. 139

1. PLACE OF DEATH: County..... <u>Frederick</u> City or town..... <u>State Sanatorium, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>Since September 25, 1944</u> Hospital, institution, or street address where death occurred: <u>Maryland Tuberculosis Sanatorium</u> How long in hospital or institution?..... <u>Since Sept. 25, 1944</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>143 N. Gay St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Louise Dunfee</u>				3. (b) Social Security Number <u>578-22-1007</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>			
6. (b) Name of husband or wife				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Sept. 2, 1924</u>							
8. AGE: Years <u>20</u>		Months <u>4</u>		Days <u>14</u>		If less than one day hrs. min.	
9. Birthplace <u>Pennsylvania</u> (Town, county, and state)							
10. Usual occupation <u>Painter</u>							
11. Industry or business							
FATHER	12. Name <u>Micheal Dunfee</u>						
	13. Birthplace <u>New York</u>						
MOTHER	14. Maiden name <u>Mable Fulmer</u>						
	15. Birthplace <u>Pennsylvania</u>						
16. Informant <u>Deceased</u> Address.....							
17. (Burial, cremation, or removal. Which?) <u>Transportation to</u> Location..... <u>Tylersburg, Pa.</u> 18. Funeral director <u>M. L. Creager & Son</u> Address..... <u>Thurmont, Maryland</u>							
19. (Date rec'd by registrar) <u>4/6/45</u> 19..... Registrar.....							

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>January 16</u> 19..... <u>45</u> at <u>4 P.</u> M	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>September 25</u> 19..... <u>44</u> to <u>Jan. 16</u> 19..... <u>45</u> and that I last saw her alive on <u>January 16</u> 19..... <u>45</u> Immediate cause of death <u>Pulmonary Tuberculosis</u> Other conditions (Include pregnancy within 8 months of death) Major findings of operations Date of op..... Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....	
23. SIGNATURE <u>J. B. Lynn</u> Address..... <u>State Sanatorium, Md.</u> Date signed..... <u>1/17/45</u>	

RECEIVED

RECEIVED

RECEIVED

FEB 6 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

00501

Reg. Dist. No. 70 140

1. PLACE OF DEATH:
County Frederick
City or town Woodsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Frederick
City or town Blumsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Samuel T. Eyles

3. (b) Social Security Number none

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married
8.(b) Name of husband or wife Mary Stambough Eyles
7. Birth date of deceased (mo., day, yr.) Jan 31, 1866
6.(c) If alive, give age _____ years

8. AGE: Years 78 Months 11 Days 9
If less than one day _____ hrs. _____ min.

9. Birthplace MD
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name William J. Eyles

13. Birthplace MD

14. Maiden name Mary A. Eyles

15. Birthplace MD

16. Informant Mrs Mary Stambough Eyles

Address Woodsboro Rt #1

17. Date thereof Jan 13, 1945
(Burial, cremation, or other) _____ (month) (day) (year)

Cemetery or crematory Rocky Hill

Location near Woodsboro, MD

18. Funeral director Ed Sussexson

Address Danentown MD

19. Jan 13 1945 Ethel M. Mchugh
(Date rec'd by registrar) _____ Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10, 1945 19____ at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 10 1945

and that I last saw him alive on Jan 10, 1945

Immediate cause of death Myocardial Infarction

DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ed Eustis Day M. D. or other

Address Worchesville, MD Date signed 1/15/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

FEB 2 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

00502

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

118 Jefferson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 Jefferson Street

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

ELLEN J. E. FLINN

3. (b) Social Security Number

None4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 30, 18568. (c) If alive, give age 45 years8. AGE: Years 88 Months 1 Days 0 If less than one day hrs. min.9. Birthplace Jefferson-Frederick-Maryland
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Thomas Flinn13. Birthplace Baltimore, Maryland14. Maiden name Margaret Cramer15. Birthplace Baltimore, Maryland16. Informant Records Taken from Family Bible

Address

17. Burial 2/3/45

(Burial, cremation, or removal - Which?) (month) (day) (year)

Cemetery or crematorium St. Pauls Lutheran CemeteryLocation Jefferson, Maryland19. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 1-45 1945 Elizabeth H. Hark

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him live on Jan 31 1945Immediate cause of death Exposure, freezingDURATION 1 hr.Due to Fall on ice

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1.30.45Where did injury occur? Frederick, Frederick, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall on ice Injured at work? no23. SIGNATURE P. W. Bow Deputy Med. Ex.Address Frederick Co. Date signed 1.31.45

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

00503

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 yearsHospital, institution, or street address where death occurred:
118 Jefferson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 Jefferson Street
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

FANNIE M. FLINN

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
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8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 15, 1866

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>5</u>	<u>15</u>hrs.min.

9. Birthplace Jefferson-Frederick-Maryland
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Thomas Flinn13. Birthplace Baltimore, Maryland14. Maiden name Margaret Cramer15. Birthplace Baltimore, Maryland16. Informant Record taken from Family Bible

Address

17. Burial Date thereof 2/3/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or ~~removal~~ St. Pauls Lutheran CemeteryJefferson, Maryland

Location

18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 1- Feb 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h.e. Jan 31 1945Immediate cause of death Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op

Autopsy results Confirmed death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. W. Ban Physician

M. D. or other

Address Frederick, Md. Date signed 1.31.45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

00504

Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 years
 Hospital, institution, or street address where death occurred:
118 Jefferson Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 118 Jefferson Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME
LILLIE L. FLINN

3. (b) Social Security Number
None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 4, 1869 6. (c) If alive, give age years

8. AGE: Years 75 Months 10 Days 27 If less than one day hrs. min.

9. Birthplace Jefferson-Frederick-Maryland
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Thomas Flinn

13. Birthplace Baltimore, Maryland

14. Maiden name Margaret Cramer

15. Birthplace Baltimore, Maryland

16. Informant Record taken from Family Bible

Address

17. Burial Burial Date thereof 2/3/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Lutheran Cemetery

Location Jefferson, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 1-Feb 19 45 Elizabeth G. Hesch
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 19 45 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and to Jan 31 19 45
 and that I last saw him live on Jan 31 19 45

Immediate cause of death Exposure to cold DURATION 8 hrs

Due to Home fire going out

Due to Death of her sister

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 1-30-45

Where did injury occur? Frederick, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Home

Means of injury Unheated house Injured at work? no

23. SIGNATURE P. W. Barr Deputy Med Ex.

Address Frederick, Md. Date signed 1-31-45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

00505

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

243 East Church Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 243 East Church Street

(If rural, give LOCATION)

None

2.(a) If veteran, name war.

3. (a) FULL NAME

BABY FORD

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
--------------------	------------------------------	--

6.(b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) January 19, 1945

6.(c) If alive, give age.....years

8. AGE: Years <u>0</u>	Months <u>0</u>	Days <u>0</u>	If less than one day <u>15</u> hrs. min.
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9. Birthplace Frederick-Frederick-Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name George D. Ford13. Birthplace Frederick County Maryland14. Maiden name Elsie McBride15. Birthplace Frederick County Maryland16. Informant George D. FordAddress 243 E. Church St., Frederick, Md.17. Burial Date thereof 1/20/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 20-Jan-1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20th, 19 45, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 19 45, to Jan 19 19 45
and that I last saw him alive on Jan 19 19 45.

Immediate cause of death

Placental T. Remia
Pregnancy

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Howard W. Wick M. D.

M. D. or other

Address Frederick, Maryland Date signed 1-20-45

WESTERN STATE TREATMENT OF INMATES

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age of deceased is shown on

FILM No G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00506

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

116 South Market Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 South Market Street

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

SARAH CATHERINE FRALEY

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife Robert Fraley

7. Birth date of deceased (mo., day, yr.) January 24, 1875

6. (c) If alive, give age years

8. AGE: Years 69 75 Months 0 Days 1 If less than one day
hrs. min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name James G. Topper

13. Birthplace Littlestown, Penna.

14. Maiden name Elizabeth Ashbaugh

15. Birthplace Frederick County Maryland

16. Informant Mrs. Louisa Schill

Address Frederick, Maryland

17. Burial Date thereof 1/29/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 26 Jan 19 45
(Date rec'd by registrar)

Elizabeth G. Beck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25th 19 45, at 7:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 24th 1945 to Jan 25th 1945
and that I last saw him alive on Jan 25th 1945

Immediate cause of death

Septicemia of Lungs
and metastasis of
carcinoma of
stomach

Due to

Metastasis of Carcinoma of Stomach

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

E. H. Hedger

M. D.

M. D. or other

Address Frederick, Maryland

Date signed 1-26-45

RECEIVED

RECEIVED

RECEIVED

FEB 5 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00507

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
City or town State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since March 16, 1943
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Since March 16, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 516 Dryer Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Virginia R. Frantz

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 4, 1924 6.(c) If alive, give age years

8. AGE: Years 20 Months 10 Days 17 If less than one day hrs. min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Roy L. Frantz

13. Birthplace Cumberland, Maryland

14. Maiden name Ada M. Lucas

15. Birthplace Cumberland, Maryland

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1/23/45
(month) (day) (year)

Cemetery Zion Memorial

Location Cumberland, Maryland

18. Funeral director William H. Kight

Address Cumberland, Maryland

19. (Date rec'd by registrar) 1/21/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 45 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 43 to Jan. 21 19 45
and that I last saw her alive on January 21 19 45

Immediate cause of death Pulmonary Tuberculosis DURATION 4 Yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. B. Lynn M. D. XXXX

Address State Sanatorium, Md. Date signed 1/22/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
JAN 30 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

00508

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: County..... Frederick City or town..... Hansonville (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... 2 yrs. Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Maryland County..... Frederick City or town..... Hansonville (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war..... None			
3. (a) FULL NAME Jacob Henry Fry				3. (b) Social Security Number None			
4. Sex Male		5. Color or race White		6. (a) Single, married, widowed, or divorced Married			
B. (b) Name of husband or wife Viola Conard				6. (c) If alive, give age 71 years			
7. Birth date of deceased (mo., day, yr.) February 5-1865							
8. AGE: Years 79		Months 11		Days 2		If less than one dayhrs.min.	
9. Birthplace Frederick County Md. (Town, county, and state)							
10. Usual occupation Retired Food Merchant							
11. Industry or business							
FATHER	12. Name Charles W. Fry						
	13. Birthplace Virginia						
MOTHER	14. Maiden name Mary Erdman						
	15. Birthplace Frederick County Md.						
18. Informant Mrs. Viola Fry Address Hansonville, Md.							
17. Burial (Burial, cremation, or removal. Which?) Date thereof..... Jan. 11-1945 (month) (day) (year) Cemetery or crematory..... Knoxville Cemetery Location..... Knoxville - Ind. 18. Funeral director C.E. Cline and Son Address Frederick, Md.							
19. 9-Jan (Date rec'd by registrar)..... 1945- Registrar Elizabeth G. Heck							
MEDICAL CERTIFICATION 20. DATE OF DEATH Jan. 7th. 1945 at 10 A. M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 7 1945 and that I last saw him alive on Jan 6 1945. Immediate cause of death Coronary thrombosis DURATION Due to..... Due to..... Other conditions..... (Include pregnancy within 8 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?..... 23. SIGNATURE O. E. Cline Address Wolbertville, Md. M. D. or other..... Date signed..... 1/8/45							

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

Mr. Eastman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-2

00509

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

County FrederickCity or town Brunswick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Schaeffer Hospital

How long in hospital or institution?

28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Knoxville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Kate Ruth Garrett

3. (b) Social Security Number

—

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

George B. Garrett6. (c) If alive, give age 73 years

7. Birth date of

deceased (mo., day, yr.)

Dec 23 1879

8. AGE:

Years

65

Months

—

Days

23

It less than one day

hrs.

min.

9. Birthplace

Penn

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

home

12. Name

Yacob Ruth

13. Birthplace

Penn.

14. Maiden name

Mary Martin

15. Birthplace

Penn.

16. Informant

George B. Garrett

Address

Knoxville Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 19, 1945
(month) (day) (year)

Cemetery or crematory

St. Marks

Location

near Beltsville Md.

18. Funeral director

C. H. Fute & Son

Address

Brunswick Md.

19.

(Date rec'd by registrar)

19 18 19 45Eugene Martin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 45, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 20 19 44, to June 16 19 45and that I last saw him alive on June 16 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Schaeffer

M. D. or other

Address

Brunswick Md.

Date signed

June 16 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V S

JAN 01 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00510

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 hrs.

Hospital, institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Urban Adamstown - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.I.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Norman Edwards Gibbs3. (b) Social Security Number
none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Jan. 1st., 1945

8. AGE:

Years

Months

Days

It less than one day

12

hrs.

min.

9. Birthplace

Frederick, Frederick, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Walter Z. Gibbs,

13. Birthplace

Grove City, Ohio

MOTHER

14. Maiden name

Catherine Knott,

15. Birthplace

Urbana, Maryland

18. Informant

Mr. Walter Z. Gibbs,

Address

Adamstown, Md.

17.

Burial

Date thereof

Jan. 3, 1945

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Catholic Cemetery

Location

Urbana, Md.

18. Funeral director

M. R. Etchison & Son,

Address

Frederick, Md.

19.

3 Jan
(Date rec'd by registrar)

19.45-

Elizabeth G. Heck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 1 -

19.45- at 11:25 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1/1

19.45-

to

1/1

19.45-

and that I last saw him alive on

1/1

19.45-

Immediate cause of death

Premature Birth - 6 + months
(Spontaneous)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. S. White, M.D.

M. D. or other

Address

Portersville, Md.Date signed 1/2/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF CHURCH

18. SIGNATURE OF OTHER

19. SIGNATURE OF

20. SIGNATURE OF

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123. SIGNATURE OF

124. SIGNATURE OF

125. SIGNATURE OF

126. SIGNATURE OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

00511

CERTIFICATE OF DEATH

Reg. Dist. No. 131

FILM No G 92 MAR 10 1945

1. PLACE OF DEATH:
County Frederick
City or town Point of Rocks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Point of Rocks
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

RICHARD ELIAS HANES

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M
B. (b) Name of husband or wife Mary M. Lowery
7. Birth date of deceased (mo., day, yr.) October 22, 1861 6. (c) If alive, give age 70 years
8. AGE: Years 83 Months 84- Days 7 If less than one day
..... hrs. min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Henry Hanes
13. Birthplace Maryland
14. Maiden name Catherine Harrison
15. Birthplace Maryland

16. Informant Mrs. Mary L. Hanes
Address Point of Rocks, Maryland

17. Burial 1/31/45
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory St. Pauls Cemetery
Location Point of Rocks, Maryland

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. 31-Jan 1945 Elizabeth G. Hech.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th, 1945 at 1:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 12 1945 to Jan 29 1945
and that I last saw him alive on Jan 28 1945

Immediate cause of death Myocarditis - Decomposed
DURATION 10 Days

Due to Acute Infarct DURATION 17 Days

Due to Senility

Other conditions Chronic Cystitis DURATION 6 yrs

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op.

Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE A. J. Quie M. D.
Jefferson Wap M. D. or other
Address — Date signed 1/30/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00512

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town Johnsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Maurice Henry Harbaugh

3. (b) Social Security Number

220-09-80954. Sex M5. Color or race W.6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Genevieve Bone6. (c) If alive, give age 26 years7. Birth date of deceased (mo., day, yr.) Dec. 22, 19158. AGE: Years 29 Months 0 Days 25 It less than one day _____ hrs. _____ min.9. Birthplace near Libertytown Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business County Road Work12. Name Chas. H. Harbaugh13. Birthplace Walkersville, Md.14. Maiden name Fannie B. Engleberger15. Birthplace Mt. Pleasant, Md.16. Informant Mrs. Maurice H. HarbaughAddress Johnsville, Md.17. Burial Date thereof Jan. 20, 1945
(Burial, exhumation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Hope CemeteryLocation 2 Woodsboro, Md.18. Funeral director Bozell & HartylerAddress 2 Woodsboro, Md.19. 19-Jan-1945 Eligabeth G. Hede
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17, 1945 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him and Jan 17, 1945 on _____Immediate cause of death Myocardial
infarction, thrombosis

DURATION

15 minDue to Cerebral ThrombosisDue to auto accident

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-17-45Where did injury occur? Mountainside Frederick, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) County RoadMeans of injury Crushed between
two trucks Injured at work? yes23. SIGNATURE P. W. Bone Deputy med
ex.

M. D. or other

Address Frederick, Md. Date signed 1-17-45

CERTIFICATE OF DEATH

SMALLPOX (VARIOLA MAJOR)

MEDICAL CERTIFICATION

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

00518

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 63 years
 Hospital, institution, or street address where death occurred:
119 West Second Street
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 119 West Second Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

LOUISA A. HUNT HENDRICKSON

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Widowed</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife John D. Hendrickson
 Deceased
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 19, 1858

8. AGE:	Years <u>86</u>	Months <u>11</u>	Days <u>5</u>	If less than one day _____ hrs. _____ min.
---------	--------------------	---------------------	------------------	---

9. Birthplace Indianapolis, Indiana
 (Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business None

12. Name David Boyd Hunt

13. Birthplace Maryland

14. Maiden name Mary A. Henshaw Correll

15. Birthplace Berkley County, Virginia

18. Informant R. Anas Hendrickson

Address Frederick, Maryland

17. Burial Jan. 26, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Frederick, Maryland

18. Funeral director C. E. Cline & Son

Address Frederick, Maryland

19. 25 Jan 45 13 45 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945 at 11A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to Jan 24 1945

and that I last saw him alive on Jan 24 1945

Immediate cause of death _____

DURATION _____

Cerebral Hemorrhage Sudden

Due to arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. O. Thomas M. D. or other _____

Address Frederick, Md Date signed Jan 25 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

Dr. Van Dr. Smith
Dr. E. P. Allen

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00514

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Frederick City Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Net Amy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. h. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME Stella M. Hoffman

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Thomas Hoffman

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace Carroll County Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Hennis W. Wuddear

13. Birthplace Maryland

14. Maiden name Annie Coleberg

15. Birthplace Maryland

16. Informant Miss Flora Wuddear

Address Net Amy Md. R. h. 2

17. Burial Date thereof Jan. 27-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cheney Cemetery

Location Winfield, Md.

18. Funeral director Wm. H. Hester, Sons

Address Union Budget News Clinton, Md.

19. Jan 28 19. 45 Elizabeth J. Hech
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 19. 45 at 9 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 19. 45 to Jan 25 19. 45

and that I last saw her alive on Jan 25 19. 45

Immediate cause of death Chronic myocarditis

DURATION 7

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE E. O. Thomas

M. D. or other

Address Frederick, Md. Date signed Jan 25-45

CERTIFICATE OF DEATH

THE STATE DEPARTMENT OF HEALTH

STATE OF CALIFORNIA

MEDICAL CERTIFICATE

RECEIVED

FEB 5 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00515

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

29 Hamilton Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FREderickCity or town FREderick
(If outside city or town limits, write RURAL and give nearest town)Street No. 29 Hamilton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

John S. Hooper

3. (b) Social Security Number

214-10-17564. Sex Male5. Color or race white6. (a) Single, married, widowed, or divorced ✓6. (b) Name of husband or wife Eva Hooper7. Birth date of deceased (mo., day, yr.) Jan 20, 1878

6. (c) If alive, give age _____ years

8. AGE: Years 66 Months 11 Days 80 It less than one day _____ hrs. _____ min.9. Birthplace Myersville Fredk. Co., Md.
(Town, county, and state)10. Usual occupation day laborer

11. Industry or business

12. Name James Hooper13. Birthplace Myersville14. Maiden name Flora Gilbert15. Birthplace Myersville16. Informant Mrs. Catherine FisherAddress Frederick17. Burial Date thereof 1 15 45
(Burial, cremation, or other) (month) (day) (year)Cemetery or crematory LutheranLocation Middletown18. Funeral director Bladhill Co.Address Middletown19. 15 Jan 19 45 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945 at 11:5A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12 1945 to Jan 12 1945and that I last saw him alive on Jan 12 1945Immediate cause of death Coronary Thrombosis DURATION 2h

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Elizabeth G. Heck M. D. or other _____Address Frederick Date signed 1/12/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70)

00516

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH: *Frederick*
 County.....
 City or town.....*near Phone 4*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Frederick*
 City or town.....*Phone 4*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert Leoy Hopkins

3. (b) Social Security Number

4. Sex.....*M* 5. Color or race.....*C* 6.(a) Single, married, widowed, or divorced.....*S*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*April 2 1944* 8.(c) If alive, give age.....years

8. AGE: Years..... Months..... Days..... If less than one day.....hrs.min.

9. Birthplace.....*Frederick Co*
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....*William A. Lee*13. Birthplace.....*Frederick Co.*14. Maiden name.....*Ethel Mae Hopkins*15. Birthplace.....*Frederick Co*16. Informant.....*Ethel Mae Hopkins*Address.....*Mt. Airy R 7 D #1*17. *Burial* Date thereof.....*Jan. 4, 1945*
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....*Simpson Chapel*Location.....*New Market*18. Funeral director.....*H. M. Snyder*Address.....*Mt. Airy rd.*19. *Jan 3* 19 *45* *Lucian K. Falconer*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Aug 3rd* 19 *45*, at *9:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19....., to.....19....., and that I last saw him.....alive on.....19.....

Immediate cause of death.....*malnutrition*Due to.....*difficult feeding*

Due to.....

Other conditions.....*rickets*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*E. C. McFarver Co. Reg.*Address.....*Frederick Co.* Date signed.....*Aug 3-1945*

RECEIVED

FEB 7 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00517

CERTIFICATE OF DEATH

Reg. Diat. No. 132

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.....

(Burial, cremation, or removal) Which?

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.....

(Date rec'd by registrar)

19.....

Marie Gladhill

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

1945 at 9:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 1945 to Jan 13 45

and that I last saw him alive on Jan 15 45

Immediate cause of death.....

DURATION

Cerebral Hemorrhage

13 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 1-16-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

00518

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 day
 Hospital, institution, or street address where death occurred:
 307 Sherman Avenue
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick
 City or town..... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 307 Sherman Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3. (a) FULL NAME

Infant Boy Kimmell

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Male	White	Single	

6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... January 18-1945
 8. AGE: Years Months Days If less than one day
 0 0 1 hrs. min.

9. Birthplace..... Frederick County Maryland
 (Town, county, and state)
 10. Usual occupation..... Infant
 11. Industry or business.....

FATHER	12. Name..... Lloyd F. Kimmell Jr.
	13. Birthplace..... Frederick County Md.
MOTHER	14. Maiden name..... Pauline Ausherman
	15. Birthplace..... Frederick County Md.

18. Informant..... Lloyd F. Kimmell Jr.
 Address..... 307 Sherman Ave.-Frederick, Md.

17. Burial Date thereof..... Jan. 20-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Mount Olivet Cemetery
 Location..... Frederick, Md.

18. Funeral director..... C.E.Cline and Son
 Address..... Frederick, Md.

19. 20 Jan 1945 Elizabeth G. Hech
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 19th. 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1945 to Jan 19 1945
 and that I last saw him alive on Jan 19 1945

Immediate cause of death.....
 Premature 8 month
 asphyxiation
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... H. Lawrence Finkney MD
 Address..... Frederick Md Date signed..... 1-20-45
 M. D. or other

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

Dr. February
1945

M

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

00519

Reg. Dist. No. 131

1. PLACE OF DEATH:
County..... Frederick
City or town..... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Lifetime
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
119 N. Market Street
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Frederick
City or town..... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 119 N. Market Street
(If rural, give LOCATION)
2.(a) If veteran, name war..... None

3. (a) FULL NAME CLARA GRANT KLINE
3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
B.(b) Name of husband or wife.....
T. Birth date of deceased (mo., day, yr.) January 3-1869 6.(c) If alive, give age..... years
8. AGE: Years 76 Months 0 Days 14 If less than one day hrs. min.
9. Birthplace..... Frederick County Maryland
(Town, county, and state)
10. Usual occupation..... Housekeeper
11. Industry or business.....
FATHER 12. Name..... William H. Kline
13. Birthplace..... Maryland
MOTHER 14. Maiden name..... Mary Ann Englebrecht
15. Birthplace..... Maryland
16. Informant..... Miss Mary Ann Kline
Address 119 N. Market St.-Frederick, Md.
17. Burial Date thereof Jan. 19-1945
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick, Md.
18. Funeral director..... C.E. Cline and Son
Address Frederick, Md.
19. 18 Jan 1945 Elizabeth G. Hesch Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Jan 19 1945 2a
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 to Jan 16 1945
and that I last saw him alive on Jan 16 1945
Immediate cause of death Coronary Thrombosis
Due to Arterio Sclerosis and Hypertension
Other conditions.....
(Include pregnancy within 8 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?
23. SIGNATURE..... H. H. Heggen M. D. or other
Address..... Frederick, Md. Date signed Jan 19 1945

HAWAIIAN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, HAWAII

RECEIVED
FEB 5 1945
BUREAU V.S.

Mr. J. H. Hedges

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

00520

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick-Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Adamstown - Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Forrest Grove

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (a) FULL NAME

GEORGE EDWARD LEAPLEY

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) September 14, 1873 6.(c) If alive, give age..... years

8. AGE: Years 71 Months 4 Days 0 If less than one day..... hrs. min.

9. Birthplace Forrest Grove-Frederick-Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business.....

12. Name George E. Leapley

13. Birthplace Hancock, Penna.

14. Maiden name Margaret Eader

15. Birthplace Hancock, Penna.

16. Informant Miss Margaret Leapley
 Address Washington, D. C.

17. Burial Date thereof 1/16/45
 (Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy Cemetery

Location Beallsville, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 15 Jan 1945 Elizabeth G. Hick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14th, 1945, at 5:35A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1945 to Jan 14 1945 and that I last saw him alive on Jan 14 1945

Immediate cause of death Cardiac-vascular-renal Disease

DURATION ?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Howard W. Cook M. D.

M. D. or other

Frederick, Maryland 1-15-45
 Address..... Date signed.....

RECEIVED
JAN 26 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 842

CERTIFICATE OF DEATH

00521

Reg. Dist. No. 139

1. PLACE OF DEATH:

County FredrickCity or town Farmville Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County FredrickCity or town Farmville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Josephine Pearl Lewis

3. (b) Social Security Number

MD4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 4 - 19218. AGE: Years 23 Months 2 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Farmville Fredrick Co MD
(Town, county, and state)10. Usual occupation at home

11. Industry or business _____

12. Name Unknown

13. Birthplace _____

14. Maiden name Helen P. Lewis15. Birthplace Farmville Fredrick Co MD16. Informant Helen P. LewisAddress Sanct MD17. Burial Date thereof Jan. 24 - 1945
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory BethelLocation near Garfield18. Funeral director M. J. TreasonAddress Thurmont MD19. Jan 24 19 45 St A. Wilk
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 19 45 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 22 19 45 to Jan. 22 19 45

and that I last saw him alive on _____ 19 _____

Immediate cause of death _____

Exhaustion

Due to _____

Insanity

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James A. Gray M.D.Address Thurmont MD Date signed 1-22-45

RECEIVED
FEB 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick-Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Near Frederick

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 908 Motter Avenue

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3.(a) FULL NAME

RAYMOND HENCH LINTON

3.(b) Social Security Number

214-10-5937

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M6.(b) Name of husband or wife Annie E. Hoover6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.)

October 12, 1889

8. AGE:

Years

Months

Days

If less than one day

55226

hrs.

min.

9. Birthplace

Nr. Hansonville-Frederick-Md.

(Town, county, and state)

10. Usual occupation

Trainman

11. Industry or business

H & F Railroad Company

12. Name

Samuel I. Linton

13. Birthplace

Loudoun County Virginia

14. Maiden name

Mary E. Stone

15. Birthplace

Frederick County Maryland

16. Informant

Mrs. Annie H. Linton

Address

908 Motter Ave., Frederick, Md.

17. Burial

(Burial, cremation, or removal, which)

Date thereof

1/10/45

(month) (day) (year)

Cemetery or crematory

Mount Olivet Cemetery

Location

Frederick, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19.

9 Jan 1945

19.

45Elizabeth G. Heck

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 8

19

45 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him live on Jan 8 1945

Immediate cause of death

Evisceration & extreme laceration of trunk

DURATION

Immediate

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 1-8-45Where did injury occur? Montrose, Frederick Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) MTF R.R.Means of Injury Run over by train at work? yes

23. SIGNATURE

R. W. Boer

M. D. or other

Address Frederick Md Date signed Jan 8, 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00522

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CHRISTIANITY OF HEALTH

RECEIVED
FEB 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

00523

Reg. Dist. No. 134

1. PLACE OF DEATH:

County FrederickCity or town Emmitsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? nine yearsHospital, institution, or street address where death occurred:
Saint Joseph's

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
Maryland FrederickState Emmitsburg CountyCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sister Mary Rose McCafferty (Rose McCafferty)

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Sister of Charity

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) (unknown) 18628. AGE: Years 83 Months Days If less than one day
hrs. min.9. Birthplace Donegal County, Ireland
(Town, county, and state)10. Usual occupation Nursing in Hospital or Mental

11. Industry or business

12. Name William McCafferty13. Birthplace Donegal, Ireland14. Maiden name Mary McThane15. Birthplace Donegal, Ireland18. Informant Sister Rosa, AssistantAddress St. Joseph's College17. Emmitsburg, Md. Date thereof January 15, '45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Joseph'sLocation Emmitsburg, Md.18. Funeral director A. L. AllisonAddress Emmitsburg, Md.19. Jan 14 19 45 M. F. Shuff
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1945 19 45 at 1 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 44 to Jan 13 19 45
and that I last saw him alive on Dec 21 19 44

Immediate cause of death

DURATION

Chronic Endocarditis 5 yrsDue to Chronic Rheumatism 10 yrsDue to Chronic Internal Sclerosis 10 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Morris A. Burt M.D. or otherAddress Thurmont, Md. Date signed 1/13/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7423

CERTIFICATE OF DEATH

00524

Reg. Dist. No. 141

1. PLACE OF DEATH:

County FredrickCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrickCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

John Madison Miller

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mary E. Faye6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

Oct. 9th 1884

8. AGE:

60Y.27— hrs. — min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Grocery

MOTHER FATHER

12. Name

Jacob M. Miller

13. Birthplace

Virginia

14. Maiden name

Sarah Mann

15. Birthplace

Virginia

16. Informant

Mrs. G. M. Miller

Address

Knoxville Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof Jan. 9, 1945
(month) (day) (year)

Cemetery or crematory

Brownsville

Location

Brownsville Md.

18. Funeral director

C. H. Feste & Son

Address

Brownsville Md.

19.

(Date rec'd by registrar)

Jan. 9, 1945Emma Martini
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 6 1945 to Jan. 6 1945and that I last saw him alive on Jan. 6 1945

Immediate cause of death

Coronary thrombosis

DURATION

1 hour

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Brownsville Date signed Jan. 8, 1945

DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466

00525

131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
Frederick City Hospital
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 44 East Third Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

NANNIE VANLEAR MUNDEY

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M
 6. (b) Name of husband or wife Harry E. Munday
 7. Birth date of deceased (mo., day, yr.) June 26, 1867 6. (c) If alive, give age 83 years
 8. AGE: Years 77 Months 6 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Near Shepherdstown W. Va.
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Dennis M. Daniels
 13. Birthplace Virginia

MOTHER 14. Maiden name Marianna Sperry
 15. Birthplace West Virginia

16. Informant Mr. Harry E. Munday
 Address 44 E. 3rd St., Frederick, Md.

17. Burial Date thereof 1/25/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mount Olivet Cemetery
 Location Frederick, Maryland
M. R. Etchison and Son

18. Funeral director Frederick, Maryland
 Address

19. 23 Jan 1945 Elizabeth L. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1945 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1944 to Jan 23, 1945
 and that I last saw him alive on Jan 23, 1945

Immediate cause of death Carcinoma Stomach Liver
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE EP Thomas M. D.
Frederick, Maryland M. D. or other
 Address _____ Date signed 1-23-45

ATTACH TO TRANSMITTED STATE OR FARM

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00526

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
27 East Third Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 27 East Third Street
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

ROSALIE HICKMAN PAXSON

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W
 6. (b) Name of husband or George O. Paxson
 7. Birth date of deceased (mo., day, yr.) October 17, 1875
 6. (c) If alive, give age _____ years
 8. AGE: Years 69 Months 2 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Point of Rocks-Frederick-Md.
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER
 12. Name George H. Hickman
 13. Birthplace Loudoun County Virginia
 14. Maiden name Mary E. Ritchie
 15. Birthplace Loudoun County Virginia

16. Informant Mrs. George J. Phillips
 Address Baltimore, Maryland

17. Burial Date thereof 1/29/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mount Olivet Cemetery
Frederick, Maryland
 Location

18. Funeral director M. R. Etchison and Son
 Address Frederick, Maryland

19. 27 Jan 19 45 Elizabeth B. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1945 at 3:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26 19 45 to Jan. 26 19 45
 and that I last saw him alive on Jan 26 19 45

Immediate cause of death Coronary Thrombosis
 DURATION 1 hour

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Wm M Smith M. D.

Address Frederick, Maryland Date signed 1-27-45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILE NO. 100-100000-100000

DEPARTMENT OF HEALTH

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FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00527

Reg. Dist. No. 144

1. PLACE OF DEATH:

County Fredrick
 City or town Thurmont rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Fredrick
 City or town Thurmont - rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Charles W. Price

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1945

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Thurmont, Fredrick Co. Md
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Harry Price13. Birthplace Martinsburg, W. Va.14. Maiden name Blanche Miller15. Birthplace Thurmont, Md.16. Informant Harry PriceAddress Thurmont, Md.

17. Burial Date thereof Jan 20, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory United BrethrenLocation Thurmont, Md.18. Funeral director M. R. Crager & SonAddress Thurmont, Md.

19. Jan 20 1945 Anna M. Jones
 (Date rec'd by registrar) Registrar Par Blanche S. Egle

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 17 1945, to Jan. 20 1945
 and that I last saw him alive on Jan 19 1945

Immediate cause of death Cerebral hemorrhage
 DURATION 3 days

Due to Difficult birth.

Due to Contracted pelvis (with
instrumental delivery)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ann M. Jones M.D.

Address Thurmont, Md. M. D. or other _____
 Date signed 1/20/45

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FEB 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16453

CERTIFICATE OF DEATH

00528

Reg. Dist. No. 131

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Point Of Rocks
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 12 years
 Hospital, institution, or street address where death occurred:
 Potomac River
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Frederick
 City or town..... Doubs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3. (a) FULL NAME

James Rison

3. (b) Social Security Number

None

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Don't Know
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... ? ? 1881
 8. AGE: Years..... 64 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Virginia
 (Town, county, and State)
 10. Usual occupation..... Farmer
 11. Industry or business.....
 12. Name..... James K. Rison
 13. Birthplace..... Virginia
 14. Maiden name..... Sarah Ella Florence
 15. Birthplace..... Virginia

16. Informant..... Mrs. Mary F. Morgan
 Address..... Frederick, Md.

17. Burial..... Date thereof..... 3/20/45
 (Burial, cremation, or removal, Whichever)
 Cemetery or..... Mount Olivet Cemetery
 Location..... Frederick, Md.
 18. Funeral director..... C.E.Cline and Son
 Address..... Frederick, Md.

19. 20 March 1945- Elizabeth G. Heck.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 24 1945, at 10 A.M. (?)

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

..... 19..... to 19.....
 and that I last saw him..... live on March 18 1945

Immediate cause of death..... Drowning
 DURATION..... Immediate
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... suicide Date of..... Jan 24 45
 Where did injury occur..... near Pt. of Rocks, Frank Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)..... Potomac River
 Means of Injury..... Potomac River Injured at work?.....

DR. R. W. BAER
 DEPUTY MEDICAL EXAMINER
 23. SIGNATURE..... R. W. Baer
 Address..... Frederick, Md.
 Date signed..... 3-20-45

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CERTIFICATE OF DEATH

RECEIVED

MAR 22 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

00529

Reg. Dist. No. 144

1. PLACE OF DEATH:

County... Frederick
 City or town... Sherrmont Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 20 years
 Hospital, institution, or street address where death occurred...

How long in hospital or institution?

3. (a) FULL NAME

Fannie May Shriver
 4. Sex... Female 5. Color or race... W 6. (a) Single, married, widowed, or divorced... Widowed

B. (b) Name of husband or wife... Conrad Shriver7. Birth date of deceased (mo., day, yr.)... July 16 - 1876

8. AGE: Years... 68 Months... 6 Days... 11 If less than one day... hrs. ... min.

B. Birthplace... Sherrmont Md
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... ✓FATHER 12. Name... Shadens Farnsey13. Birthplace... MarylandMOTHER 14. Maiden name... Ellen (Moser) Farnsey15. Birthplace... Maryland16. Informant... Mrs. Harry ShriverAddress... Sherrmont17. Burial Date thereof... 1 - 29 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... United BrethrenLocation... Sherrmont18. Funeral director... Willie B. CraggsAddress... Sherrmont19. Jan. 29 1945 Anna M. Jones
(Date rec'd by registrar) RegistrarPer Blanche S. Egan

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Frederick
 City or town... Sherrmont Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ...
 (If rural, give LOCATION)

2. (a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 27 1945, at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 24 1945, to Jan. 27 1945and that I last saw her alive on Jan. 26 1945Immediate cause of death... Cerebral Hemorrhage

DURATION

3 days

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... James T. Gray Md

M. D. or other

Address... Sherrmont Md Date signed... 1/29/45

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FEB 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1957

00530

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
Frederick City HospitalHow long in hospital or institution? 2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 26 Franklin Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

DOROTHY MAY SHECKELS

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 25, 1944 6.(c) If alive, give age..... years8. AGE: Years 1 Months 0 Days 0 If less than one day..... hrs. min.9. Birthplace Frederick-Frederick-Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business.....

FATHER 12. Name Robert Sheckels13. Birthplace Mount Airy MarylandMOTHER 14. Maiden name Eleanor Kemp15. Birthplace Frederick County Maryland16. Informant Robert SheckelsAddress 26 Franklin St., Frederick, Md.17. Burial Date thereof 1/29/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 26 Jan 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1945 at 6 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Jan 25 1945and that I last saw him alive on Jan 25 1945

Immediate cause of death..... DURATION

Obstruction in 4 hrs.Due to possible infectedbone found on someDue to foreign substance

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE R. Thomas M. D. or otherAddress Frederick, Maryland Date signed 1-26-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00531

Reg. Dist. No. 131

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 30 yrs.
 Hospital, institution, or street address where death occurred:
 38 South Market Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick
 City or town..... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 38 South Market Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... None

3. (a) FULL NAME

Laura Anders Sinclair

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife..... ? Sinclair
 T. Birth date of deceased (mo., day, yr.)..... February 8-1872
 8. AGE: Years..... 72 Months..... 10 Days..... 28 It less than one day..... hrs. min.

9. Birthplace..... Frederick County Maryland
 (Town, county, and state)

10. Usual occupation..... Retired Housewife

11. Industry or business.....

FATHER 12. Name..... Michael Anders

13. Birthplace..... Woodsboro, Md.

MOTHER 14. Maiden name..... Mary Catherine Hardman

15. Birthplace..... Frederick County Maryland

16. Informant..... Charles Anders

Address..... Frederick, Md.

17. Burial Date thereof..... January 9-15
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory..... Mount Hope Cemetery

Location..... Woodsboro, Maryland

19. Funeral director..... C.E. Cline and Son

Address..... Frederick, Md.

19. 9-Jan 1945 Elizabeth G. Heck Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 5th..... 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on Jan 5

Immediate cause of death.....

.....

.....

.....

Due to.....

.....

Due to.....

.....

Other conditions.....

.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

.....

23. SIGNATURE..... P. W. Ban

..... M. D. or other

Address..... Frederick, Md.

Date signed..... 1-8-45

UNITED STATES DEPARTMENT OF JUSTICE

CONFIDENTIAL - DEATH

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FEB 5 1945
BUREAU V.S.

Mr. Baer

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32-0

CERTIFICATE OF DEATH

00532

Reg. Diat. No. 131

1. PLACE OF DEATH:

County Fredrick
 City or town Fredrick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hrs
 Hospital, institution, or street address where death occurred:
Fredrick City Hospital
 How long in hospital or institution? 1 1/4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
 City or town Mt Airy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Ann Smith

3. (b) Social Security Number

✓

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 16 1938 B. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
6 1 9 _____ hrs. _____ min.

9. Birthplace Fredrick City Hosp. Fredrick Md
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Care W Smith13. Birthplace Maryland14. Maiden name B. Hazel Duwall15. Birthplace Maryland18. Informant Care W SmithAddress Mt Airy Md

17. Burial Date thereof 1/29/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Five Groves CemeteryLocation Mt Airy Md18. Funeral director Ray BarberAddress Haytownsville Md

19. 25 Jan 1945 Elizabeth H Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to Jan 25 1945
 and that I last saw him alive on Jan 25 1945

Immediate cause of death

Cardiac Failure
Coronary Arteriosclerosis
 Due to Acute Respiratory Distress
(Pneumonia)

DURATION

3 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

C. M. Van Poole
Mt Airy Md M. D. or officer
 Address _____ Date signed 1/25/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

REPORT OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00533

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Rocky Ridge- Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 50 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Frederick
 City or town..... Rocky Ridge- Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 No
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George Smith.

3. (b) Social Security Number

None.

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... March 14, 1856
 6.(c) If alive, give age..... years

8. AGE: Years..... 88 Months..... 10 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Hanover, Penna.
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Farmer

12. Name..... George Smith.

13. Birthplace..... Germany.

14. Maiden name..... Elizabeth Warick.

15. Birthplace..... Hanover, Pa.

16. Informant..... Mrs. Maurice Eby.

Address..... Rocky Ridge, Md.

17. Burial Date thereof Jan. 25, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rocky Ridge- Mt Tabor.

Location..... Rocky Ridge, Md.

18. Funeral director..... M. L. Creager & Son.

Address..... Thurmont, Md.

19. Jan. 25, 1945
 (Date rec'd by registrar) Anna M. Jones
 Registrar Per Blanche S. Egler

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 22 1945 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 - 1945 to Jan 22 1945 and that I last saw him alive on Jan 7 1945

Immediate cause of death..... Cerebral Thrombosis
 DURATION..... 2 wks.

Due to..... Cerebral Arteriosclerosis
 DURATION..... 10 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Thurmont Md Date signed Jan. 25, 45

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FEB 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

00534

Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Frederick City Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Montgomery
 City Monrovia - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Monrovia
 (If rural, give LOCATION)
 2.(c) If veteran, name war None

3. (a) FULL NAME Smith, Mrs. Walter AUGUSTUS
 3. (b) Social Security Number 577-03-6880

4. Sex M
 5. Color or race W
 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Mattie Smith

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 11, 1886

8. AGE: Years 58 Months 7 Days 20 If less than one day
hrs.min.

9. Birthplace Wentworth, N. C.
 (Town, county, and state)

10. Usual occupation Wholesale Tobacco Saleman

11. Industry or business

12. Name Richard Smith

13. Birthplace North Carolina

14. Maiden name Rebecca Vaughn

15. Birthplace North Carolina

16. Informant Mrs. Walter A. Smith

Address Monrovia, Md. Rural

17. Burial Date thereof 2/3/45
 (Burial, cremation, or removal, whichever) (month) (day) (year)

Cemetery or crematory Bethesda Cemetery

Location Browningsville, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 1- Feb 19 45 Elizabeth Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 19 45, at 9²⁵ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 26 19 45 to Jan. 31 19 45

and that I last saw him alive on Jan. 31 19 45

Immediate cause of death Acute Coronary Thrombosis

Due to 1 day

Due to Myocardium

Other conditions Branchial Cyst

(Include pregnancy within 3 months of death)

Major findings of operations None

Antopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Austin Carter, M.D.
Frederick, Md. M. D. or other

Address Frederick, Md. Date signed 2/3/45

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00535

Reg. Dist. No. 138

1. PLACE OF DEATH:

County Frederick
 City or town New Market
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Frederick
 City or town New Market
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

Wm E W. Smith

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Ada McCracken
(dead)

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Jan 22, 1866

8. AGE:

Years

Months

Days

If less than one day

781125

_____ hrs.

_____ min.

9. Birthplace

Frederick Co., Md
(Town, county, and state)

10. Usual occupation

Farmer (Retired)

11. Industry or business

12. Name

Washington Smith

13. Birthplace

Frederick Co., Md

14. Maiden name

Julia Ogle

15. Birthplace

Frederick Co., Md

16. Informant

Clyde W. Smith

Address

1 Gansville, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1/19/45
(month) (day) (year)

Cemetery or crematory

Mt. Olivet

Location

Frederick Md

18. Funeral director

Harry E. Garty Co

Address

Frederick, Md.

19. Jan 18

(Date rec'd by registrar)

19. 45

Judson K. Falconer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 17, 1945 at 12:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 6, 1945 to Jan 15, 1945
and that I last saw him alive on January 15, 1945

Immediate cause of death

Myocardial Infarction

DURATION

Due to

Due to

Other conditions

cholesterol

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Frederick, Md

Date signed

Jan 17, 1945

RECEIVED
FEB 7 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

742

00536

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

County..... **Frederick**
 City or town..... **Brunswick**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Schnauffers Hospital Brunswick, Md.
 How long in hospital or institution?..... **15 Minutes**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **West Va.** County..... **Jefferson**
 City or town..... **Bolivar, W. Va.**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

John Olivar Sponseller

3. (b) Social Security Number

705-07-1013

4. Sex..... **Male**
 5. Color or race..... **White**
 6.(a) Single, married, widowed, or divorced..... **Married**
 6.(b) Name of husband or wife..... **Mary Kathryn Sponseller**
 6.(c) If alive, give age..... **63** years
 7. Birth date of deceased (mo., day, yr.)..... **June 17 1881**
 8. AGE: Years..... **63** Months..... **6** Days..... **19**
 If less than one day..... hrs. min.

9. Birthplace..... **Bolivar, W. Va.**
 (Town, county, and state)
 10. Usual occupation..... **B. & O. Bridge Inspector**
 11. Industry or business..... **B. & O. R.R.**
 12. Name..... **Cannon Sponseller**
 13. Birthplace..... **Bolivar, W. Va.**
 14. Maiden name..... **Lucy Strider**
 15. Birthplace..... **Jefferson, Co. W. Va.**
 16. Informant..... **Mrs John Sponseller**
 Address..... **Bolivar, W. Va.**

17. **Burial** Date thereof..... **Jan 7 1945**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Luthern Cemetery**
 Location..... **Bolivar, W. Va.**
 19. Funeral director..... **J. H. Leach**
 Address..... **Bolivar, W. Va.**

19. **Jan 6 1945** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Jan 5 1945** at **4:15 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan 2** to **Jan 5** and that I last saw him alive on **Jan 5**

Immediate cause of death..... **Coronary Occlusion**
 Due to..... **Arteriosclerosis**
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **S. J. Moore**
Harpers Ferry, W. Va. M. D. physician
 Address..... Date signed..... **1/6/45**

CERTIFICATE OF DEATH

BUREAU V.S.

JAN 17 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County Frederick
 City or town Rocky Ridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland. County Frederick
 City or town Rocky Ridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

Charles Albert Staub.

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.
 6. (b) Name of husband or wife Lillie M. Staub.
 6. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) May 27, 1867
 8. AGE: Years 77 Months 8 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Rocky Ridge, Frederick Co., Md
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Staub.
 13. Birthplace Rocky Ridge, Md.
 MOTHER 14. Maiden name Catherine Mathers
 15. Birthplace Md

16. Informant Mrs. Charles Staub
 Address Rocky Ridge, Md.

17. Burial Date thereof Feb. 1, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt Tabor Cemetery.
 Location Rocky Ridge, Md.

18. Funeral director M. L. Creager & Son
 Address Thurmont, Md.

19. Jan 31 19 45
 (Date rec'd by registrar) Anna M. Jones
Pho Blanche S. Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 to 44 to Jan 29 19 45
 and that I last saw him alive on Jan 28 19 45

Immediate cause of death Heart disease, organic
chronic myocarditis with
valvular insufficiency
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James Gray M.D.
Thurmont, Md M.D. or other
 Address _____ Date signed 1/31/45

RECEIVED

FEB 6 1945

BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186

CERTIFICATE OF DEATH

Reg. Dist. No. 131

00538

1. PLACE OF DEATH:

County... Frederick
 City or town... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 442 W. South St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick
 City or town... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 442 W. South Street
 (If rural, give LOCATION)
 World War 1
 2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES LEWIS WALTERS

3. (b) Social Security Number

219-12-1668

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 26-1892
 6.(c) If alive, give age years

8. AGE: Years 52 Months 9 Days 9 If less than one day
hrs.min.

9. Birthplace... Frederick County Maryland
 (Town, county, and state)

10. Usual occupation... Painter

11. Industry or business

12. Name... Charles E. Walters

13. Birthplace... Berkley Springs, West Virginia

14. Maiden name... Ellen Hartsock

15. Birthplace... Penna.

16. Informant... Charles E. Walters

Address... 442 W. South St.-Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof... Jan. 7-1945
 (month) (day) (year)

Cemetery or crematory... Oak Hill Cemetery

Location... near Woodsboro, Md.

18. Funeral director... C.E. Cline and Son

Address... Frederick, Md.

19. 5 Jan 1945 Elizabeth S. Hech Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 4th. 1945, at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Jan 4 1945

Immediate cause of death... Subdural hemorrhage
 DURATION 6 days

Due to... Fall on ice

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... at home Date of Dec 27 43

Where did injury occur? Frederick Frederick Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury Fall on ice Injured at work? 40

23. SIGNATURE... R. W. Barr

Address... Prof. R. W. Barr
 Date signed... 1. 3. 45

CERTIFICATE OF DEATH

RECEIVED

JAN 22 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

00539

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred:
129 South Market StreetHow long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 129 South Market Street
(If rural, give LOCATION)2.(a) If veteran, name war -----

3. (a) FULL NAME

SARAH KATE WATERS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single8.(b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) May 7, 1864 6.(c) If alive, give age ----- years8. AGE: Years 80 Months 8 Days 11 If less than one day ----- hrs. ----- min.9. Birthplace Frederick, Frederick Co., Maryland
(Town, county, and state)10. Usual occupation Retired Housekeeper11. Industry or business None12. Name Horatia Waters13. Birthplace Frederick, Maryland14. Maiden name Rachel O. Hogg15. Birthplace Elkton, Maryland16. Informant Miss Maggie WatersAddress Frederick, Maryland17. Burial Date thereof Jan. 20, 1945
(Burial, cremation, or removal of body) (month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation Frederick, Maryland18. Funeral director C. E. Cline & SonAddress Frederick, Maryland19. 18 Jan 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 19 45, at 12:15 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ----- 19 ----- to ----- 19 -----and that I last saw her dead Jan 18 19 45
alive on -----Immediate cause of death Cerebral occlusion DURATION ImmediateDue to HypertensionDue to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public places (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Robert J. Smith M.D.Address Frederick, Md M. D. or other -----Date signed 1.18.45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1945
BUREAU V.S.

Dr. Thacker

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 0054931

1. PLACE OF DEATH:

County Frederick
 City or town Frederick City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Days
 Hospital, institution, or street address where death occurred:
Frederick City Jail
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Frederick
 City or town Brunswick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10 South Delaware ave
 (If rural, give LOCATION)
 2.(a) if veteran, name war 710

3. (a) FULL NAME

Vernon Edgar Weber

3. (b) Social Security Number

705-10-4191

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Goldie Lorna Campbell6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, year)

July 14 1889

8. AGE:

55 Years6 Months4 Days

If less than one day

.....hrs.min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

P.O. R. R. Brakeman

11. Industry or business

Transportation

MOTHER FATHER

12. Name

John Weber

13. Birthplace

Virginia

14. Maiden name

Sarah Adams

15. Birthplace

Virginia

16. Informant

Mrs Goldie Weber

Address

Brunswick Md.

17. Burial

BurialDate thereof Jan - 20-1945

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Reform Cemetery

Location

Brunswick

18. Funeral director

Chas. F. F. F. F.

Address

Brunswick Md.

18 Jan 1945

19 45

Elizabeth G. Heck

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... to

and that I last saw him alive on Jan 18 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

1 hr.

Due to

Hypertension

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

P. W. Barr

M. D. or other

Address

Frederick, Md.Date signed 1-18-45

RECEIVED
JAN 24 1945
BUREAU A

RECEIVED
JAN 24 1945
BUREAU A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

00541

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 140 E. South St.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Margaret Kay Ecker White

3. (b) Social Security Number

none.4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Chas. E. White7. Birth date of deceased (mo., day, yr.) July 12 18848. AGE: Years 60 Months 5 Days 29 If less than one day hrs. min.9. Birthplace Carroll Co. Md.
(Town, county, and state)10. Usual occupation House wife11. Industry or business Own home12. Name David E. Ecker13. Birthplace Md.14. Maiden name Elizabeth West15. Birthplace Md.16. Informant Mrs. Dorothy EastonAddress 476 W. Patrick St. Frederick, Md.17. Burial Date thereof Jan 15 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union ChapelLocation near Liberty town Md.18. Funeral director Bowell & HartzlerAddress 2 Woodsboro Md.19. 13 Jan 19 45 Elizabeth S. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 19 45 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw her alive on Jan 11 19 45Immediate cause of death Coronary occlusion

DURATION

1 hr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE R. W. Baer

M. D. or other

Address Frederick, Md. Date signed 1/12/45

14-00000

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 100

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

RECEIVED
FEB 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1316)

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Jefferson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Jefferson
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME

Miss. Hattie Moore Wise

3.(b) Social Security Number

none

4. Sex <u>female</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>single</u>
-------------------------	----------------------------------	--

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 15th., 1867

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>0</u>	<u>14</u>hrs.min.

9. Birthplace Jefferson, Frederick, Maryland
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Henry C. Wise,13. Birthplace Nr. Middletown, Md.14. Maiden name Alverta Sparrow,15. Birthplace Jefferson, Md.16. Informant Mr. Harry W. Wise,Address Jefferson, Md.17. Burial Date thereof Feb. 1, 1945
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory St. Pauls Lutheran CemeteryLocation Jefferson, Md.18. Funeral director M. R. Etchison & Son,Address Frederick, Md.19. 31-Jan 45- Elizabeth H. Heck
(Date rec'd by registrar) (Year) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th., 1945, at 8.05P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3, 1945 to Jan 29, 1945 and that I last saw him alive on Jan 29, 1945Immediate cause of death Pulmonary edemaDue to MyocarditisDue to decompensatedDue to Coronary diseaseOther conditions Chronic Hypertosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE C. P. WiseAddress Jefferson, Md.Date signed Jan. 30, 45

00542

RECEIVED

RECEIVED

RECEIVED

FEB 5 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00543

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick

City or town Frederick City Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Frederick City Hospital

How long in hospital or institution? Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Frederick

City or town New Market MD
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry Wood

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Elise Smith Wood

7. Birth date of deceased (mo., day, yr.) Nov 27 - 1867

8. AGE: Years 77 Months 2 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace New Market MD
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Charles Wood

13. Birthplace MD

14. Maiden name Katie Worthington

15. Birthplace MD

16. Informant Mrs. Elise Smith Wood

Address New Market MD

17. Burial (Burial, cremation, or removal, whichever) Burial Date thereof Jan 9 - 1945
(month) (day) (year)

Cemetery or crematory New Market Cemetery

Location New Market MD

18. Funeral director W.E. Falconer

Address New Market MD

19. 8 Jan 19 45 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9/45 19 45, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29 19 44 to Jan 9 19 45

and that I last saw him alive on Jan 7 19 45

Immediate cause of death Chronic Myocarditis

Due to Cardiovascular

Due to Renal disease

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Couley

Address Frederick M. D. or other _____

Date signed 1/8-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Tolson

Mr. Marshall

RECEIVED
FEB 5 1945
BUREAU V.S.